PROOF OF ELIGIBILITY

State Form 53549 (3-08) / FI 2430

Reset Form

Agency Information

Family and Social Services Administration Document Center
PO Box 1810
Marion, Indiana 46952

Telephone Number: 1-800-403-0864

Case Information

Full Name:	Date of Birth:
Case Number:	Social Security Number:
Home Address:	Mailing Address:

Scheduled Appointment

Appointment Type:	Appointment Date:	Scheduled Time:	Office Location (In-Office Only)

Pending Applications

Programs Applied For:	Date Application Received:

Assistance Groups

Type of Assistance:

DETAILS	
Status:	
Category Sequence:	
Effective Date:	
End Date:	
Monthly Spend-down or Liability (Medicaid Only):	

PENDING VERIFICATIONS

Pending Verifications:

ASSISTANCE GROUP CLIENTS

Names:	Participation Status:	Effective Date:	End Date:

AUTHORIZED REPRESENTATIVE

Primary Name:	Primary Address:

Type of Assistance:

DETAILS	
Status:	EBT Card Benefit Availability Date:
Category Sequence:	Current Month Amount:
Effective Date:	Next Month Amount:
End Date:	Redetermination Month:
Monthly Spend-down or Liability (Medicaid Only):	

PENDING VERIFICATIONS

Pending Verifications:

ASSISTANCE GROUP CLIENTS

Names:	Participation Status:	Effective Date:	End Date:

AUTHORIZED REPRESENTATIVE	
Primary Name:	Primary Address:

Type of Assistance:

DETAILS	
Status:	EBT Card Benefit Availability Date:
Category Sequence:	Current Month Amount:
Effective Date:	Next Month Amount:
End Date:	Redetermination Month:
Monthly Spend-down or Liability (Medicaid Only):	

PENDING VERIFICATIONS

Pending Verifications:

ASSISTANCE GROUP CLIENTS

Names:	Participation Status:	Effective Date:	End Date:

AUTHORIZED REPRESENTATIVE	
Primary Name:	Primary Address: